parent questionniare

Please answer all questions as completely as possible and **make a copy for your records**.
All information is confidential.

Client Information:

Child's Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Form Completed By: _____

Relationship to Child: _____

Address: _____

Primary Phone: _____ Alternate Phone: _____

Email Address: _____

Describe concerns regarding the child's speech, language, literacy or learning development:

_____

_____

_____

Please share the child's strengths and/or interests:

_____

_____

_____

_____

Family Information:

Parent/Guardian: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
Email: _____

Parent/Guardian: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
Email: _____

Child lives with:

☐ Birth Parents ☐ Foster Parents ☐ One Parent
☐ Adoptive Parents ☐ Parent and Stepparent ☐ Other

Describe custody if necessary:

_____

_____

_____

Other children/ extended family living in the household:

	Name	Age	Relationship	Grade
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____ .
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Please note any **family history** of the following (immediate or extended family)?

☐ Speech/Language Delays ☐ Reading difficulty/Dyslexia ☐ ADD
☐ Learning Difficulties ☐ Hearing Loss ☐ Other

Is there a second language spoken in the home? **Yes / No**

If yes, which language(s)?_____

Which language does the child prefer to speak at home? _____

Birth & Medical History:

Any illnesses or accidents during pregnancy? Yes / No (If yes, please explain)

_____

_____

_____

_____

Length of Pregnancy: _____ Duration of Labor:_____ Birthweight: _____

Was delivery considered normal? Yes / No (If no, please explain)

_____

_____

_____

_____

Please note any conditions/complications shortly after birth.

- ☐ Jaundice
- ☐ Low Apgar scores
- ☐ Drug additions
- ☐ NICU stay
- ☐ Other_____

Does the child have any pertinent medical history or diagnosis? Yes / No
If yes, please mark and explain

- ☐ Genetic disorder _____
- ☐ Seizures _____
- ☐ Diabetes _____
- ☐ Sleep Difficulties _____
- ☐ Head Injury _____
- ☐ Surgeries _____
- ☐ Other _____

Does the child have any known **food allergies?** Yes / No (If yes, please list and describe)

_____

_____

_____

_____

Is the child taking any medications? Yes / No (If yes, please list)

_____

_____

_____

_____

Hearing:

Does the child have a history of ear infections? Yes / No

If yes, approximately how many _____ , and what ages _____.

PE Tubes? Yes / No

Has the child had his/her tonsils and adenoids removed? Yes / No

Has the child's hearing ever been tested? Yes / No
If yes:
Date of Testing: _____ Results of Testing: Normal / Abnormal

Feeding & Oral Development:

Did the child have any feeding problems early in life? Yes / No (If yes, please describe)

_____

_____

_____

If the child was bottle fed, at what age did he/she stop using bottle? _____

Is the child able to drink from a straw? Yes / No

Did the child drool past 2 years of age? Yes / No

Is the child a picky eater or are there any foods child refuses to eat? Yes / No

Does the child suck his/her thumb or use a pacifier? Yes / No

Does the child have any food allergies or on a restricted diet? Yes / No (If yes, please explain)

_____

_____

_____

Developmental Milestones:

At what age did the child acquire each developmental milestone? N/A if not yet completed.

Language Skills	Age	Comments
Coo & Babble, "bababa"		
First Words		
Combine 2-3 words,"more juice"		
Used 2-3 word sentences		
Asked Questions		
Gross Motor	Age	Comments
Sit independently		
Crawl		
Walk		
Pedal tricycle		
Fine Motor	Age	Comments
Independently get dressed		
Trace Shapes		
Write her/his name		
Cut along lines with scissors		

Do you feel the child is well coordinated? Yes / No Explain:

_____

_____

_____

What is the child's dominant hand: Right Left Undetermined

Does the child use 3-finger pencil grip? Yes / No

Is the child toilet trained? Yes / No If yes, at what age was your child toilet trained? _____

Play & Social Skills:

The child has **noted difficulty** with the following (please check all that apply):

- ☐ Greeting people when arriving or leaving
- ☐ Engaging in eye contact
- ☐ Maintaining conversation
- ☐ Turn taking
- ☐ Recalling or telling about everyday events
- ☐ Answering questions
- ☐ Following one/two-step directions
- ☐ Transitioning from one activity to another
- ☐ Behavior challenges
- ☐ Anxiety
- ☐ Attention

Speech & Language History:

What is the child's primary way of communicating?

☐ Eye contact ☐ Gestures ☐ Jargon ☐ Words ☐ Sign Language ☐ Sentences

Does the child have difficulty formulating sounds or words? Yes / No (If yes, please explain)

_____

_____

_____

Does the child appear to have age-appropriate grammar/sentence structure? Yes / No (If no, please explain)

_____

_____

_____

Is the child's speech understandable? ☐ To you ☐ To family ☐ To friends

Does the child appear to understand what you say (directions, questions)? Yes / No

Please give an estimate of how many words are in the child's vocabulary:

Receptive (words he/she understands) _____

Expressive (words spoken) _____

Is the child aware of, or frustrated by, any speech-language-literacy difficulties? Yes / No
(If yes, please describe)

_____

_____

_____

_____

Do you and your spouse agree on the problem and how it should be handled? Yes / No
Please explain:

_____

_____

_____

_____

School & Daycare Information:

Does the child attend daycare? Yes / No
Location: _____ How often: _____

Does the child attend preschool? Yes / No
Location: _____ How often: _____

Name of School & School District:_____ Grade: _____
If retained, what grade: _____

Is the child receiving services under an Individual Education Plan (IEP) or 504 Plan?

- ☐ No
- ☐ Yes

If yes, please attach a copy to this questionnaire.

Has a psycho-educational assessment been completed by a Psychologist?

- ☐ No
- ☐ Yes, through the school district
- ☐ Yes, privately

If yes, please attach a copy to this questionnaire

Has the child received any of the following evaluations or therapeutic services?

		Date	Name/Agency
☐	Developmental Pediatrician	_____	_____
☐	Psychiatrist/Psychologist	_____	_____
☐	Neurologist	_____	_____
☐	Speech Language Therapy	_____	_____
☐	Occupational Therapy	_____	_____
☐	Physical Therapy	_____	_____
☐	Ophthalmologist/Vision	_____	_____
	☐ Child wears glasses		
☐	Tutoring	_____	_____

PLEASE ATTACH ALL REPORTS PERTINENT TO THE CHILD'S THERAPY AT THE SACRAMENTO SCOTTISH RITE CHILDHOOD LANGUAGE CENTER

- ☐ I've attached a copy of the child's most recent IEP
- ☐ I've attached a copy of all previous speech/language/literacy assessments.
- ☐ I've attached a copy of the child's psycho-educational assessment
- ☐ I've attached a copy of other pertinent assessments and therapy reports
- ☐ I've attached other important documents

The California Scottish Rite Foundation requires that all incoming clients be up to date with all required immunizations. Documentation in the form of a signed statement from a medical doctor must be provided to the Center prior to enrollment.

- ☐ I've attached a copy of signed **Immunization Form**
- ☐ I've attached a copy of signed **Authorization for Release of Information**
- ☐ I've attached a copy of signed **Policy Agreement**
- ☐ I understand my child's file will not be reviewed until all required forms are submitted.

If you have any additional information which you feel would be helpful to us in preparing for an evaluation and/or in working with the child, please share below.

_____

_____

_____

_____

_____

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Thank you for taking the time to complete this form.